MEMORIAL HEALTH SYSTEM

COMMUNITY • HEALTH • EXCELLENCE • LIFE

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____, hereby authorize Memorial Health System to release copies of medical and
(patient name)
other information concerning my hospitalization or treatment including, but not limited to, information concerning drug abuse or drug-related conditions, alcoholism, psychological and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions or sexual preference, or permit review of same, provided, however that such release is limited specifically to material of the following nature and extent. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure resulting in my health information no longer being protected by Federal confidentiality rules.

Records disclosed by: ___ Marietta Memorial Hospital ___Selby General Hospital ___Sistersville General Hospital

Treatment Date:_____ ___Inpatient ___Emergency ___Outpatient
Patient Name:_____
Date of Birth:_____
Social Security Number:_____

__Complete Chart	__Operative/Pathology Report	__Case Summary
__Face Sheet	__Physician Orders/Progress Notes	__Nursing Notes
__History/Physical	__Emergency Room Report	__Test Results

__Other_____
Specific Exclusions:_____

The above information is to be release to:
Person/Facility:_____
Address:_____
e-Mail Address _____

Delivery Method: __US Mail __Pick-Up __Fax __ Unencrypted e-Mail (please be advised that e-Mail is not fully secure when transmitted over the internet)
Purpose of Disclosure:
__Insurance __Continuity of Care __Personal __Legal __Other_____

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS
I understand this authorization may be revoked at any time except to the extent action has been taken prior to revocation. Memorial Health System may not condition treatment or eligibility for benefits on whether you sign this authorization. This consent will expire in one year after the date below or sooner at my election in which case this authorization will expire on _____. I release the hospital of any liability which may arise as a result of any subsequent disclosure of my health information by the recipient.

_____ _____
DATE SIGNATURE OF PATIENT

_____ _____
WITNESS OTHER PERSON LEGALLY AUTHORIZED TO GIVE CONSENT

_____
RELATIONSHIP

This information has been disclosed to you from records protected by Federal law. Federal regulations (42 CFR part 2) may prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general authorization for the release of medical and other information is not sufficient for this purpose.

According to Federal and State law there may be a charge for creating copies of medical records. The fee will be dependent on the number of copies and media utilized.